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A NEW METHOD OF PERFORMING VAGINAL FIXATION.*

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My object in presenting this preliminary report is to place myself on record as having devised this method independently of any one else. I incidentally referred to it in a short paper on the Indications for Vaginal Fixation, read before the Obstetric Section of the Academy of Medicine, February 27, 1896, and mentioned two cases in which I had followed it.† Although I make no claim of priority, I feel I am entitled to originality of conception. The train of thought and consequent procedure of action has been so similar with Wertheim, of Vienna, and myself, that the charge of plagiarism might be readily made by either of us were it not excluded by the chronicle of events.

During the past four months gynæcological literature, in Germany at least, has devoted a great deal of attention to the subject of the difficulties encountered during pregnancy and labor after ventral and vaginal fixation of the uterus. On studying Miländer's report ‡ of cases of dystocia following ventral fixation, I was struck with the circumstance that it occurred solely in cases operated on after the Leopold method, in which the fundus was sutured directly to the abdominal wall, and that no difficulty was met with in cases operated upon after Olshausen's method, in which the uterus was fixed by suturing the round ligaments and a portion of the broad ligament. The dystocia occurring after vaginal fixation was due to the same condition as obtained in ventral fixation with Leopold's method—*i. e.*, it was due to a too extensive and firm union of the fundus with the vagina. The

* Read before the New York Obstetrical Society, April 7, 1896.

† *Medical News*, March 14, 1896.

‡ *Zeitschr. für Geburtsh. und Gynäk.*, Bd. xxxiii, Heft 3.

thought then occurred to me that Olshausen's method could be carried out in vaginal fixation, with the simple difference that for the point of fixation the vaginal would be substituted for the abdominal wall. Although I myself had not met with any disturbances in pregnancy and labor after vaginal fixation, and none had been observed in cases operated upon after a method similar to that which I had been practicing, still I determined to fix the uterus to the vagina by suturing to it the round ligaments instead of the fundus This mode of procedure, if successful, I thought would be valuable in women still in the fruitful period, as it would entirely preclude the possibility of dystocia as a result of the operation.

The first opportunity presented itself on February 4, 1896, when I was operating on a patient thirty-five years old, who had a retroflexion of the third degree, descensus of the first degree, laceration of the cervix, cystocele the size of a hen's egg, and relaxation of the posterior vaginal wall.

After making the usual incision the fundus was delivered, and then the annexa, which were visually inspected, and a few cysts in one ovary punctured. The annexa were then returned. A suture of silkworm gut was passed on either side, about two centimetres from the horn of the uterus, embracing the round ligament and a portion of the broad ligament. The fundus was then replaced, and the sutures carried through the vaginal flaps at a point immediately behind the pubic arch, and laterally where the vaginal wall is reflected to the side of the pubic rami. Next an anterior colporrhaphy was done and the vaginal flaps sutured in the usual way. An amputation of the cervix and a perinæorrhaphy completed the series of operations.

The uterus was in fair position after the operation, not, however, so well forward and lying against the vaginal wall as in my other cases of vaginal fixation. I operated on a second case two days later, following the same technique with one addition. I carried an additional suture across the anterior surface of the uterus midway between the os internum and the fundus and through the vaginal flaps. A suture thus placed could not possibly be the means of bringing about a condition (too extensive and firm union of the fundus) which could give rise to trouble in pregnancy or at labor, but would make more certain the permanent results of the operation. My experience thus far bears out the correctness of the latter assumption. The first case shows a tendency to relapse ; the fundus now lies midway between the promontory and symphysis pubis. In the second case the uterus is in an ideal forward position, and, judging from my experience with other

cases, I am safe in saying that it will remain in good forward position.

To recapitulate the technique :

1. Longitudinal incision in the anterior vaginal wall and free dissection of the flaps on either side.

2. Transverse incision of the peritoneal fold.

3. Delivery of the fundus if there exists any suspicion of disease of the annexa, otherwise bringing it well into the incision. In this step traction sutures and volsella should, if possible, be avoided. If there be no firm or extensive adhesions the uterus may be anteverted by passing two fingers through the peritoneal incision over the fundus and bringing it forward. Pressure over the pubes with the hand may materially assist in this procedure.

4. Passing a suture either of silk or silkworm gut (catgut would be absorbed too quickly) on either side around the round ligament and a portion of the adjacent broad ligament at a point one or two centimetres from the horn of the uterus.

5. Passing a transverse suture across the anterior surface of the uterus midway between the os internum and fundus.

6. Carrying the round-ligament fixation sutures through the vaginal flaps on either side at a point corresponding to the lateral sulcus of the vagina immediately behind the pubic arch, and carrying the uterine fixation suture through the vaginal flaps a centimetre from their margin.

7. Closing the peritoneal slit with a continuous catgut suture.

8. Closing the vaginal wound by a continuous catgut suture.

9. Fixation sutures to be removed at the end of three or four weeks.

Now as to Wertheim's work in the same direction. In the *Centralblatt für Gynäkologie* (No. 2) for January 11, 1896, there is an article by him, Ueber Verlauf von Geburt und Schwangerschaft bei vaginofixirtem Uterus (The Behavior of Labor and Pregnancy in a Vaginofixated Uterus). At the close of the article he refers to the fact that Olshausen's method in ventral fixation had not been attended with difficulty at labor. "Perhaps," he adds, "this circumstance may lead to a corresponding modification of vaginofixation. It is certain that in this operation it is possible to fix the adjacent structures of the round ligaments instead of the body of the uterus."

The journal containing this article did not reach me until the first week in February, when I had already done my first case. It did not influence me in my second case, as I modified my method of

procedure as detailed above—and shall do so in the future—as fixation by the round ligaments alone, in my opinion, does not afford a sufficient guarantee of permanent results.

Wertheim has another article in the *Centralblatt für Gynäkologie*, 1896, No. 10, March 7th, entitled Neue Methode der Vaginalen Antefixatio Uteri (New Methods of Antefixation of the Uterus).

In this paper he reports five cases in all. In two of them, on closing the slit in the peritonæum the round ligaments were sutured to both angles of the peritoneal wound and not directly to the vaginal wall. He recognizes the uncertainty of the result attending this method. In two other cases the ligaments were sutured directly to the vaginal flaps. In the fifth case he did what he terms "a vaginal Alexander-Adams operation." The round ligament was shortened as follows: The ligament at its exit from the uterus was sutured to another portion of it from seven to nine centimetres distant. The intervening part was disposed of by the formation of a fold. Every one will recognize the similarity of this procedure to that devised by one or more Fellows of this Society, and known as "shortening of the round ligaments within the abdomen." *

Six days ago I operated at St. Mark's Hospital on a third case, following exactly the same technique as in the second case. I desire to state here that three days ago, the last time I saw the second patient on whom I had operated, she complained of occasional stitches above both Poupart's ligaments. The uterus was in good position; there was no sensitiveness on pressure over either annexa, which appeared to be normal. The symptom was evidently due to dragging upon the round ligaments, and, I believe, is not an uncommon one after Alexander's operation.

* The objections to intraperitoneal shortening of the round ligaments has been well stated by Dr. C. Cleveland.